		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 W. ANTLE (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: 217-632-2249 **Fax #** 217-632-2314

IDPA ID Number: 37-0856151001

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/00 to 11/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	Skilled (SNF)	59	21,535	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,855	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,916	1,916	8
9	SNF/PED					9
10	ICF	12,554	4,945		17,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,554	4,945	1,916	19,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.85%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / /66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1,916

Medicare Intermediary ADMINISTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/01 Fiscal Year: 11/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	78,331	9,754	4,326	92,411		92,411		92,411			1
2	Food Purchase		62,162		62,162		62,162	(2,137)	60,025			2
3	Housekeeping	23,852	6,657		30,509		30,509		30,509			3
4	Laundry	14,729	7,340		22,069		22,069		22,069			4
5	Heat and Other Utilities			50,994	50,994		50,994		50,994			5
6	Maintenance	24,732	11,794	22,845	59,371		59,371	702	60,073			6
7	Other (specify):* Utility workers	14,748			14,748		14,748		14,748			7
8	**TOTAL General Services**	156,392	97,707	78,165	332,264		332,264	(1,435)	330,829			8
	B. Health Care and Programs											
9	Medical Director	12,101		5,000	17,101		17,101		17,101			9
10	Nursing and Medical Records	493,671	79,272	22,986	595,929	(53,990)	541,939	1,106	543,045			10
10a	Therapy	17,711	183	102,066	119,960	(102,066)	17,894		17,894			10a
11	Activities	27,691	1,585		29,276		29,276		29,276			11
12	Social Services			2,962	2,962		2,962		2,962			12
13	Nurse Aide Training	3,497	86	4,682	8,265		8,265		8,265			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	554,671	81,126	137,696	773,493	(156,056)	617,437	1,106	618,543			16
	C. General Administration											
17	Administrative	46,406		8,064	54,470	1,382	55,852	25,937	81,789			17
18	Directors Fees											18
19	Professional Services			125,749	125,749		125,749	(119,133)	6,616			19
20	Dues, Fees, Subscriptions & Promotions			4,184	4,184		4,184	(1,783)	2,401			20
21	Clerical & General Office Expenses	20,942	6,676	3,374	30,992		30,992	12,926	43,918			21
22	Employee Benefits & Payroll Taxes			133,696	133,696		133,696	7,735	141,431			22
23	Inservice Training & Education			1,034	1,034		1,034	40	1,074			23
24	Travel and Seminar			2,177	2,177	(1,651)	526	503	1,029			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,322	82,322		82,322	288	82,610			26
27	Other (specify):*			5,331	5,331		5,331	(5,331)				27
28	**TOTAL General Administration**	67,348	6,676	365,931	439,955	(269)	439,686	(78,818)	360,868			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	778,411	185,509	581,792	1,545,712	(156,325)	1,389,387	(79,147)	1,310,240			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MENARD CONVALESCENT CENTER #0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,123	19,123		19,123	1,772	20,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			13,553	13,553		13,553		13,553			33
34	Rent-Facility & Grounds							2,791	2,791			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			32,676	32,676		32,676	4,563	37,239			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					156,325	156,325		156,325			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,085	47,085		47,085		47,085			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			47,085	47,085	156,325	203,410		203,410			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	778,411	185,509	661,553	1,625,473		1,625,473	(74,584)	1,550,889			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	577	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(693)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,727)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(694)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(392)	27		24
25	Fund Raising, Advertising and Promotional	(1,599)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,212)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(275)	20		28
29	Other-Attach Schedule VENDING	(2,137)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,152)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(64,432)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,432)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,584)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		102,066	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		1,996	10	42
43	Prescription Drugs	X		40,649	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		11,448	10	45
46	Other-Attach Schedule Med. Supp.	X		166	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 156,325		47

STATE OF ILLINOIS

Page 5A

MENARD CONVALESCENT CENTER

ID# 0003020

Report Period Beginning: 12/1/00

Ending: 11/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	226	0	0	0	0	0	0	0	0	0	226	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(694)	(118,511)	0	0	0	0	0	0	0	0	0	(119,205)	19
20	Fees, Subscriptions & Promotions	(1,874)	0	0	0	0	0	0	0	0	0	0	(1,874)	20
21	Clerical & General Office Expenses	(693)	0	0	0	0	0	0	0	0	0	0	(693)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(226)	0	0	0	0	0	0	0	0	0	(226)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(5,331)	0	0	0	0	0	0	0	0	0	0	(5,331)	27
28	**TOTAL General Administration**	(8,592)	(118,511)	0	0	0	0	0	0	0	0	0	(127,103)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,592)	(118,511)	0	0	0	0	0	0	0	0	0	(127,103)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	577	0	0	0	0	0	0	0	0	0	0	577	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	577	0	0	0	0	0	0	0	0	0	0	577	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,015)	(118,511)	0	0	0	0	0	0	0	0	0	(126,526)	45

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	25.00	D'ADRIAN CONVALESCENT CENTER, INC.	GODFREY	Nursing Home Mngrs.	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	25.00	HILLTOP NURSING HOME, INC.	CHARLESTON			
ROBERT SCHAFER	25.00	JACKSONVILLE CONVALESCENT CENTER, INC	JACKSONVILLE			
BARRY FREE	25.00	MEADOW MANOR, INC.	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 124,857	NURSING HOME MANAGERS, INC.	50.00%	$	$ (124,857)	1
2	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.		54,079	54,079	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC. DIRECT ALLOCATION		6,346	6,346	3
4	V	24	TRAVEL	226	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(226)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		226	226	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 125,083			$ 60,651	$ * (64,432)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	SAM KLEIN	PRESIDENT	MANAGEMENT	25.00					$ 1,239	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					1,239	17-7	2
3	ROBERT SCHAFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		12,101	9-1	3
4											4
5											5
6			Sam Klein and H. Raymond Klein were paid by Nursing Home Managers, Inc.,								6
7			a related organization. Total compensation of $9,240 for each Sam Klein and								7
8			H. Raymond Klein was allocated among the six related nursing homes, based								8
9			upon 10 hours per week for Sam Klein and 10 hours per week for H. Raymond Klein.								9
10											10
11											11
12											12
13								TOTAL	$ 14,579		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nursing Home Managers, Inc.
Street Address: 2653 W. Lawrence, Suite B.
City / State / Zip Code: Springfield, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5		SEE ATTTACHED SCHEDULES								5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	12,714	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	13,705	2
3. Under or (over) accrual (line 2 minus line 1).	$	991	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	12,562	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	13,553	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	13,420	8
	1997	13,496	9
	1998	13,488	10
	1999	13,870	11
	2000	13,705	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

LINE 4 ACCRUAL 11/12 * 13705 = 12562

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MENARD CONVALESCENT CENTER COUNTY MENARD

FACILITY IDPH LICENSE NUMBER 0003020

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-14-219-006	MENARD CONVALESCENT CENTI	$ 96.80	$ 96.80
2.	11-14-219-009	MENARD CONVALESCENT CENTI	$ 526.68	$ 526.68
3.	11-14-227-001	MENARD CONVALESCENT CENTI	$ 823.74	$ 823.74
4.	11-14-228-001	MENARD CONVALESCENT CENTI	$ 11,484.94	$ 11,484.94
5.	11-14-228-002	MENARD CONVALESCENT CENTI	$ 465.52	$ 465.52
6.	11-14-229-001	MENARD CONVALESCENT CENTI	$ 307.24	$ 307.24
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 13,704.92	$ 13,704.92

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	93,436	1993-1994	$ 9,919	1
2					2
3	TOTALS	93,436		$ 9,919	3

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966	$ 172,985	$ 1,397	30	$	$ (1,397)	$ 172,985	4
5	32		1974	1974	148,705	1,754	30	(657)	(2,411)	148,705	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1966	5,308					5,308	9
10	FIRE DOORS			1979	1,433					1,433	10
11	FIRE DOORS			1981	8,340					8,340	11
12	BATHROOM			1984	7,335	293	30	245	(48)	4,287	12
13	AIR CONDITIONER			1984	1,100	44	8		(44)	1,100	13
14	ELECTRICAL & PLUMBING			1985	11,117	481	15	(368)	(849)	11,117	14
15	PLUMBING			1986	4,921	207	15	164	(43)	4,921	15
16	SMOKE DETECTORS			1986	10,445	439	25	418	(21)	6,479	16
17	AIR CONDITIONER			1986	2,235	94	10		(94)	2,235	17
18	PLUMBING			1986	1,145	48	20	57	9	884	18
19	ROOF			1987	6,362	233	20	318	85	4,611	19
20	WATER HEATER & WINDOWS			1988	6,530	207	15	435	228	6,150	20
21	NURSE CALL			1988	1,674	53	10	4	(49)	1,674	21
22	ROOF			1989	30,672	974	20	1,533	559	19,174	22
23	WATER HEATER & PARKING LOT			1989	11,502	365	15	767	402	9,587	23
24	FURNACE & FLOORING			1990	19,165	608	15	1,277	669	14,696	24
25	AIR CONDITIONER			1991	2,633	84	15	176	92	1,848	25
26	PLUMBING FAUCETS			1992	8,909	283	15	594	311	5,643	26
27	DOOR ALARM			1992	1,572	50	20	79	29	868	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	138	15	290	152	2,465	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	338	208	2,535	29
30	LANDSCAPING			1994	3,900	260	15	260		1,885	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	470	289	3,055	31
32	REMODEL BATHROOMS-TILE, CEILING, FIXTURES			1996	19,751	507	15	1,317	810	7,243	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	513	33
34	FIRE DAMPERS			1998	4,076	105	15	272	167	952	34
35	FURNACE			1998	2,200	56	15	147	91	514	35
36	GREASE TRAP			1999	2,824	72	15	188	116	470	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 515,020	$ 9,107		$ 8,438	$ (669)	$ 451,677	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 116,827	$ 9,752	$ 11,185	$ 1,433	VARIOUS	$ 59,260	71
72	Current Year Purchases	1,847	264	77	(187)	VARIOUS	77	72
73	Fully Depreciated Assets	138,283					138,283	73
74	Assets No Longer in Service	(73,230)					(73,230)	74
75	TOTALS	$ 183,727	$ 10,016	$ 11,262	$ 1,246		$ 124,390	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 708,666	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,123	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,700	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 577	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 576,067	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			86		86
3	Classroom Wages	(a)	1,132	1,144		2,276
4	Clinical Wages	(b)	173	1,048		1,221
5	In-House Trainer Wages	(c)				
6	Transportation			482		482
7	Contractual Payments		1,036	2,914		3,950
8	Nurse Aide Competency Tests			250		250
9	TOTALS		$ 2,341	$ 5,924	$	$ 8,265
10	SUM OF line 9, col. 1 and 2	(e)	$ 8,265			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	762	$ 34,818	$	762	$ 34,818	1
2	Licensed Speech and Language Development Therapist		hrs		193	6,097		193	6,097	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,288	61,151		1,288	61,151	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				40,649		40,649	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen, Labs, X-ray, MC Supp.						13,610		13,610	13
14	TOTAL			$	2,243	$ 102,066	$ 54,259	2,243	$ 156,325	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 97,216	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	348,815		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,341		6
7	Other Prepaid Expenses	533		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 486,905	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	515,020		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	252,502		16
17	Accumulated Depreciation (book methods)	(637,582)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 139,859	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 626,764	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 65,641	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,355		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,580		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,562		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,212		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 111,350	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 111,350	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 515,414	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 626,764	$	48

***(See instructions.)**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 424,518	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 424,518	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	206,896	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(116,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 90,896	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 515,414	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,783,669	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,783,669	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	29,692	6
7	Oxygen	8,170	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 37,862	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,858	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,858	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,350	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,350	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 2137, Admit Fees 540, W/A 42	2,719	28
28a	Bad Debt Recovery 800, Old checks 111	911	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,630	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,832,369	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	317,516	31
32	Health Care	788,241	32
33	General Administration	439,955	33
	B. Capital Expense		
34	Ownership	32,676	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,625,473	40
41	**Income before Income Taxes (line 30 minus line 40)****	206,896	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 206,896	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 40,204	$ 19.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,227	4,774	83,989	17.59	3
4	Licensed Practical Nurses	8,846	9,462	112,791	11.92	4
5	Nurse Aides & Orderlies	33,283	34,232	256,687	7.50	5
6	Nurse Aide Trainees	668	668	3,497	5.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,008	2,156	17,711	8.21	8
9	Activity Director	1,974	2,078	13,971	6.72	9
10	Activity Assistants	2,071	2,118	13,720	6.48	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,914	2,079	20,015	9.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,993	9,347	58,316	6.24	15
16	Dishwashers					16
17	Maintenance Workers	3,519	3,670	24,732	6.74	17
18	Housekeepers	4,502	4,568	23,852	5.22	18
19	Laundry	2,452	2,465	14,729	5.98	19
20	Administrator	2,000	2,080	46,406	22.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,970	2,088	20,942	10.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,101	40.34	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	2,788	2,850	14,748	5.17	33
34	TOTAL (lines 1 - 33)	83,515	87,015	$ 778,411 *	$ 8.95	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 4,326	1-3	35
36	Medical Director	100	5,000	9-3	36
37	Medical Records Consultant	16	515	10-3	37
38	Nurse Consultant	64	1,949	10-3	38
39	Pharmacist Consultant	48	774	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	52	2,962	13-3	45
46	Other(specify) Administrative Cons.	292	8,064	17-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	716	$ 23,590		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	46	$ 1,870	10-3	50
51	Licensed Practical Nurses	606	15,212	10-3	51
52	Nurse Aides	156	2,666	10-3	52
53	TOTAL (lines 50 - 52)	808	$ 19,748		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVEN TERRITO	ADMINISTRATOR	0	$ 46,406
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 46,406

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 8,064
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 8,064

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 124,857
FELDMAN, WASSER, ET AL	LEGAL	694
CSC	CORP. REPRESENTATION	198
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 125,749

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,421
Unemployment Compensation Insurance	6,397
FICA Taxes	57,785
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	25,631
EMPLOYEE LIFE INSURANCE	1,784
HOLIDAY PARTY	337
GIFT CERTIFICATES	945
HBV VACCINE	1,396
NURSING HOME MANAGERS ALLOCATION	7,735
TOTAL (agree to Schedule V, line 22, col.8)	$ 141,431

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTY	22	$ 337
GIFT CERTIFICATES	22	945
HBV VACCINES	22	1,396
TOTAL		$ 2,678

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,493
Health Care Worker Background Check	
(Indicate # of checks performed 26)	312
YELLOW PAGES	275
PUBLIC RELATIONS	1,599
FOOD PERMIT	100
ADMINISTRATOR LICENSE	100
FRANCHISE FEE	105
NURSING HOME MNGS. ALLOCATION	91
Less: Public Relations Expense	(1,599)
Non-allowable advertising	( )
Yellow page advertising	(275)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,401

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
ADMINISTRATOR TRAVEL	526
NURSING HOME MNGS ALLOCATION	503
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,029

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/1/00 Ending: 11/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING	6/90	$ 1,471	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YRS									
3	PAINTING	7/94	2,726	3 YRS									
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MENARD CONVALESCENT CENTER **#** 0003020 **Report Period Beginning:** 12/1/00 **Ending:** 11/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **165** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SCHEDULE V

PAGE 3 LINE 27 COLUMN 3
OTHER COSTS

RT TAX	$ 3,212
SALES TAX	$ 1,727
BAD DEBT	$ 392
	$ 5,331

SCHEDULE XI

PAGE 13 SECTION E
RECONCILIATION OF DEPRECIATION

LINE 83	$ 19,700
NURSING HOME MANAGERS ALLOCATION	$ 1,195
SCHEDULE V LINE 30 COLUMN 8	$ 20,895

COLUMN 5 RECLASSIFICATION

RECLASS FROM:		LINE #
LABS	$ (488)	10
X-RAY	$ (1,508)	10
MEDICARE DRUGS	$ (40,649)	10
MEDICARE SUPPLIES	$ (166)	10
OXYGEN	$ (11,448)	10
PHYSICAL THERAPY	$ (61,151)	10A
SPEECH THERAPY	$ (6,097)	10A
OCCUPATIONAL THERAPY	$ (34,818)	10A
RECLASS TO: ANCILLARY	$ 156,325	39
RECLASS TO:		
NURSE CONSULTANT TRAVEL	$ 269	10
ADMINISTRATIVE CONSULTANT TRAVEL	$ 1,382	17
RECLASS FROM: TRAVEL	$ (1,651)	24

SCHEDULE XVII PAGE 19 LINE 41
RECONCILIATION OF INCOME

NET INCOME	$ 206,896
* ACCRUED MANAGEMENT FEE 11/00	$ (8,769)
* ACCRUED MANAGEMENT FEE 11/01	$ 13,621
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	$ (2,350)
	$ 209,398

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS

SCHEDULE XIII
PAGE 15

TRAINED AT: SUNRISE MANOR OF VIRDEN, INC
333 S. WRIGHTSMAN
VIRDEN, IL 62690

COST PER AIDE TRAINED 8 @ $504.50

PAGE 23 QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
2000

	DEC 00	JAN 01	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	2000 TOTAL	LINE #
SALARIES-ADMIN	$1,431	$2,001	$1,978	$1,896	$1,842	$1,790	$1,952	$1,953	$2,205	$2,218	$2,024	$1,944	$23,233	17
SALARIES-CLERIC	755	1,055	1,044	1,000	972	944	1,030	1,030	1,216	1,224	1,117	1,073	12,459	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	0	159	157	151	146	142	155	155	11	11	10	10	1,106	10
ACCOUNTING	7	6	6	6	6	6	6	6	6	6	6	5	72	19
WORK COMP INS	18	20	20	19	19	18	20	20	19	19	17	17	226	22
SUPPLIES	28	79	78	75	73	71	77	77	9	9	9	8	594	21
TELEPHONE	70	48	48	46	44	43	47	47	45	46	42	40	566	21
EMPL BENEFITS	377	387	383	367	356	346	378	378	473	476	435	417	4,773	22
PAYROLL TAXES	204	261	258	248	241	234	255	255	205	206	188	181	2,736	22
TRAVEL	160	63	62	59	58	56	61	61	39	40	36	35	729	24
IN SERVICE	3	3	3	3	3	3	3	3	5	5	4	4	40	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	0	13	13	12	12	11	13	13	13	13	12	11	135	6
OWNERS COMP	229	232	229	220	213	207	226	226	183	184	168	161	2,478	17
INS-PROP,LIAB,WC	21	24	24	23	23	22	24	24	27	27	25	24	288	26
DEPRECIATION	104	107	106	102	99	96	105	105	98	99	90	86	1,195	30
RENT	229	244	241	231	225	219	238	238	243	244	223	214	2,791	34
MAINTENANCE	35	39	39	37	36	35	38	38	71	71	65	62	567	6
FEES & PUBLICAT	3	4	3	3	3	3	3	3	11	11	10	10	70	20
ADVERTISING		0	0	0	0	0	0	0	6	6	5	5	21	20
		0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$3,673	$4,746	$4,693	$4,498	$4,369	$4,247	$4,631	$4,634	$4,884	$4,913	$4,484	$4,307	54,079	
FIXED ASSETS													54,079	
EQUIP - PRIOR	6,209	8,925	8,825	8,459	8,216	7,986	8,709	8,715	8,875	8,928	8,147	7,827	8,318	
EQUIP - CURR	2,859	0	0	0	203	198	216	216	220	221	202	194	377	
EQUIP - FULLY DEP	759	1,280	1,265	1,213	1,178	1,145	1,248	1,249	1,272	1,280	1,168	1,122	1,182	
BLDG - PRIOR	909	944	934	895	869	845	922	922	939	945	862	828	901	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MONTHLY CENTRAL OFFICE COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
SALARIES-ADMIN	$2,012	$1,473	$1,925	$1,921	$1,486	$1,761	$10,578
SALARIES-CLERIC	1,062	777	1,016	1,013	784	929	$5,581
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	10	7	9	9	7	8	$50
WORK COMP INS	25	18	24	24	19	22	$132
SUPPLIES	39	28	37	37	29	34	$204
TELEPHONE	98	72	94	94	73	86	$518
EMPL BENEFITS	531	389	508	507	392	465	$2,791
PAYROLL TAXES	286	210	274	273	211	251	$1,505
TRAVEL	225	165	215	215	166	197	$1,183
IN SERVICE	4	3	4	4	3	4	$22
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	0	0	0	0	0	$0
OWNERS COMP	322	236	308	308	238	282	$1,694
INS-PROP,LIAB,WC	30	22	29	29	22	26	$158
DEPRECIATION	146	107	139	139	107	127	$765
RENT	323	236	309	308	238	282	$1,696
MAINTENANCE	49	36	47	47	36	43	$257
FEES & PUBLIC	5	4	5	5	4	4	$26
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,167	$3,783	$4,943	$4,932	$3,814	$4,521	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,734	6,394	8,356	8,337	6,448	7,642	45,912
EQUIP - CURR	4,021	2,944	3,847	3,838	2,968	3,519	21,138
EQUIP - FULLY DEP	1,068	782	1,022	1,019	788	934	5,614
BLDG - PRIOR	1,279	937	1,224	1,221	944	1,119	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.64%	13.64%	18.11%	18.77%	13.52%	17.31%	100.00%
SALARIES-ADMIN	$1,972	$1,443	$1,916	$1,986	$1,431	$1,831	$10,578
SALARIES-CLERIC	1,041	761	1,011	1,048	755	966	$5,581
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	9	9	7	9	$50
WORK COMP INS	25	18	24	25	18	23	$132
SUPPLIES	38	28	37	38	28	35	$204
TELEPHONE	97	71	94	97	70	90	$518
EMPL BENEFITS	520	381	505	524	377	483	$2,791
PAYROLL TAXES	281	205	273	283	204	261	$1,505
TRAVEL	221	161	214	222	160	205	$1,183
IN SERVICE	4	3	4	4	3	4	$22
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	($0)
OWNERS COMP	316	231	307	318	229	293	$1,694
INS-PROP,LIAB,WC	29	22	29	30	21	27	$158
DEPRECIATION	143	104	139	144	104	133	$765
RENT	316	231	307	318	229	294	$1,696
MAINTENANCE	48	35	46	48	35	44	$257
FEES & PUBLIC	5	3	5	5	3	4	$26
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,064	$3,704	$4,918	$5,099	$3,673	$4,702	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,560	6,261	8,314	8,620	6,209	7,948	45,912
EQUIP - CURR	3,941	2,883	3,828	3,969	2,859	3,659	21,138
EQUIP - FULLY DEP	1,047	766	1,017	1,054	759	972	5,614
BLDG - PRIOR	1,254	917	1,218	1,263	909	1,164	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
SALARIES-ADMIN	$2,679	$1,997	$2,512	$2,617	$2,001	$2,439	$14,245
SALARIES-CLERIC	1,413	1,054	1,325	1,381	1,055	1,287	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	213	159	199	208	159	194	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	20	26	27	20	25	$145
SUPPLIES	106	79	99	104	79	97	$564
TELEPHONE	64	48	60	63	48	59	$343
EMPL BENEFITS	518	386	486	506	387	472	$2,756
PAYROLL TAXES	350	261	328	342	261	319	$1,861
TRAVEL	84	62	79	82	63	76	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	16	17	13	16	$91
OWNERS COMP	310	231	291	303	232	283	$1,650
INS-PROP,LIAB,WC	33	24	31	32	24	30	$174
DEPRECIATION	144	107	135	140	107	131	$763
RENT	327	244	307	319	244	298	$1,739
MAINTENANCE	53	39	49	51	39	48	$280
FEES & PUBLIC	5	4	4	5	4	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,356	$4,738	$5,960	$6,208	$4,746	$5,787	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,953	8,910	11,208	11,675	8,925	10,883	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,714	1,277	1,607	1,674	1,280	1,560	9,111
BLDG - PRIOR	1,265	943	1,186	1,235	944	1,152	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
SALARIES-ADMIN	$2,701	$2,019	$2,658	$2,477	$1,978	$2,412	$14,245
SALARIES-CLERIC	1,425	1,065	1,402	1,307	1,044	1,272	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	214	160	211	197	157	191	$1,131
ACCOUNTING	9	6	8	8	6	8	$45
WORK COMP INS	27	21	27	25	20	25	$145
SUPPLIES	107	80	105	98	78	95	$564
TELEPHONE	65	49	64	60	48	58	$343
EMPL BENEFITS	522	391	514	479	383	466	$2,756
PAYROLL TAXES	353	264	347	324	258	315	$1,861
TRAVEL	84	63	83	77	62	75	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	13	17	16	13	15	$91
OWNERS COMP	313	234	308	287	229	279	$1,650
INS-PROP,LIAB,WC	33	25	32	30	24	29	$174
DEPRECIATION	145	108	142	133	106	129	$763
RENT	330	247	325	302	241	294	$1,739
MAINTENANCE	53	40	52	49	39	47	$280
FEES & PUBLIC	5	4	5	4	3	4	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,407	$4,790	$6,307	$5,876	$4,693	$5,721	$33,794
FIXED ASSETS							
EQUIP - PRIOR	12,050	9,009	11,860	11,051	8,825	10,759	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,727	1,291	1,700	1,584	1,265	1,542	9,111
BLDG - PRIOR	1,275	953	1,255	1,169	934	1,138	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
SALARIES-ADMIN	$2,601	$1,892	$2,683	$2,471	$1,896	$2,703	$14,245
SALARIES-CLERIC	1,372	998	1,416	1,303	1,000	1,426	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	206	150	213	196	151	215	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	19	27	25	19	27	$145
SUPPLIES	103	75	106	98	75	107	$564
TELEPHONE	63	46	65	59	46	65	$343
EMPL BENEFITS	503	366	519	478	367	523	$2,756
PAYROLL TAXES	340	247	351	323	248	353	$1,861
TRAVEL	81	59	84	77	59	84	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	17	12	17	16	12	17	$91
OWNERS COMP	301	219	311	286	220	313	$1,650
INS-PROP,LIAB,WC	32	23	33	30	23	33	$174
DEPRECIATION	139	101	144	132	102	145	$763
RENT	318	231	328	302	231	330	$1,739
MAINTENANCE	51	37	53	49	37	53	$280
FEES & PUBLIC	5	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$6,170	$4,487	$6,365	$5,861	$4,498	$6,411	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,604	8,439	11,971	11,023	8,459	12,057	63,553
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	1,664	1,210	1,716	1,580	1,213	1,729	9,111
BLDG - PRIOR	1,228	893	1,267	1,166	895	1,276	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.181803	0.130521	0.19115	0.167163	0.12928	0.200083	1
SALARIES-ADMIN	2589.864	1859.329	2723.01	2381.308	1841.655	2850.264	14245.43
SALARIES-CLERIC	$1,366	$981	$1,436	$1,256	$972	$1,504	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	206	148	216	189	146	226	1,131
ACCOUNTING	8	6	9	8	6	9	45
WORK COMP INS	26	19	28	24	19	29	145
SUPPLIES	103	74	108	94	73	113	564
TELEPHONE	62	45	66	57	44	69	343
EMPL BENEFITS	501	360	527	461	356	551	2,756
PAYROLL TAXES	338	243	356	311	241	372	1,861
TRAVEL	81	58	85	74	58	89	445
IN SERVICE	4	3	4	4	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	17	12	17	15	12	18	91
OWNERS COMP	300	215	315	276	213	330	1,650
INS-PROP,LIAB,WC	32	23	33	29	23	35	174
DEPRECIATION	139	100	146	128	99	153	763
RENT	316	227	332	291	225	348	1,739
MAINTENANCE	51	37	53	47	36	56	280
FEES & PUBLIC	5	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	6,144	4,411	6,460	5,649	4,369	6,762	33,794
FIXED ASSETS							
EQUIP - PRIOR	11,554	8,295	12,148	10,624	8,216	12,716	63,553
EQUIP - CURR	286	205	301	263	203	315	1,574
EQUIP - FULLY DEP	1,656	1,189	1,742	1,523	1,178	1,823	9,111
BLDG - PRIOR	1,223	878	1,285	1,124	869	1,346	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
SALARIES-ADMIN	$2,523	$1,972	$2,745	$2,372	$1,790	$2,844	$14,245
SALARIES-CLERIC	1,331	1,040	1,448	1,251	944	1,500	$7,515
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	200	156	218	188	142	226	$1,131
ACCOUNTING	8	6	9	8	6	9	$45
WORK COMP INS	26	20	28	24	18	29	$145
SUPPLIES	100	78	109	94	71	113	$564
TELEPHONE	61	47	66	57	43	68	$343
EMPL BENEFITS	488	381	531	459	346	550	$2,756
PAYROLL TAXES	330	258	359	310	234	372	$1,861
TRAVEL	79	62	86	74	56	89	$445
IN SERVICE	4	3	4	4	3	4	$21
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	16	13	18	15	11	18	$91
OWNERS COMP	292	228	318	275	207	329	$1,650
INS-PROP,LIAB,WC	31	24	34	29	22	35	$174
DEPRECIATION	135	106	147	127	96	152	$763
RENT	308	241	335	290	219	347	$1,739
MAINTENANCE	50	39	54	47	35	56	$280
FEES & PUBLIC	4	3	5	4	3	5	$25
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$5,985	$4,677	$6,511	$5,628	$4,247	$6,746	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,256	8,796	12,244	10,584	7,986	12,687	63,553
EQUIP - CURR	279	218	303	262	198	314	1,574
EQUIP - FULLY DEP	1,614	1,261	1,755	1,517	1,145	1,819	9,111
BLDG - PRIOR	1,191	931	1,296	1,120	845	1,343	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
SALARIES-ADMIN	$2,498	$1,884	$2,763	$2,328	$1,952	$2,820	$14,245
SALARIES-CLERIC	1,318	994	1,458	1,228	1,030	1,488	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	198	150	219	185	155	224	1,131
ACCOUNTING	8	6	9	7	6	9	45
WORK COMP INS	25	19	28	24	20	29	145
SUPPLIES	99	75	109	92	77	112	564
TELEPHONE	60	45	66	56	47	68	343
EMPL BENEFITS	483	365	534	450	378	546	2,756
PAYROLL TAXES	326	246	361	304	255	369	1,861
TRAVEL	78	59	86	73	61	88	445
IN SERVICE	4	3	4	3	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	15	13	18	91
OWNERS COMP	289	218	320	270	226	327	1,650
INS-PROP,LIAB,WC	31	23	34	28	24	34	174
DEPRECIATION	134	101	148	125	105	151	763
RENT	305	230	337	284	238	344	1,739
MAINTENANCE	49	37	54	46	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,926	$4,470	$6,554	$5,522	$4,631	$6,690	$33,794
FIXED ASSETS							
EQUIP - PRIOR	11,145	8,407	12,326	10,385	8,709	12,582	63,553
EQUIP - CURR	276	208	305	257	216	312	1,574
EQUIP - FULLY DEP	1,598	1,205	1,767	1,489	1,248	1,804	9,111
BLDG - PRIOR	1,179	890	1,304	1,099	922	1,331	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
SALARIES-ADMIN	$2,426	$1,839	$2,794	$2,432	$1,953	$2,802	$14,245
SALARIES-CLERIC	1,280	970	1,474	1,283	1,030	1,478	7,515
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	193	146	222	193	155	222	1,131
ACCOUNTING	8	6	9	8	6	9	45
WORK COMP INS	25	19	28	25	20	28	145
SUPPLIES	96	73	111	96	77	111	564
TELEPHONE	58	44	67	59	47	67	343
EMPL BENEFITS	469	356	540	470	378	542	2,756
PAYROLL TAXES	317	240	365	318	255	366	1,861
TRAVEL	76	57	87	76	61	88	445
IN SERVICE	4	3	4	4	3	4	21
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	16	12	18	16	13	18	91
OWNERS COMP	281	213	324	282	226	324	1,650
INS-PROP,LIAB,WC	30	22	34	30	24	34	174
DEPRECIATION	130	98	150	130	105	150	763
RENT	296	224	341	297	238	342	1,739
MAINTENANCE	48	36	55	48	38	55	280
FEES & PUBLIC	4	3	5	4	3	5	25
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,756	$4,362	$6,627	$5,769	$4,634	$6,646	$33,794
FIXED ASSETS							
EQUIP - PRIOR	10,824	8,203	12,463	10,850	8,715	12,499	63,553
EQUIP - CURR	268	203	309	269	216	310	1,574
EQUIP - FULLY DEP	1,552	1,176	1,787	1,555	1,249	1,792	9,111
BLDG - PRIOR	1,145	868	1,319	1,148	922	1,323	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SALARIES-ADMIN	$2,529	$2,198	$3,101	$2,744	$2,205	$3,010	$15,787
SALARIES-CLERIC	1,396	1,213	1,711	1,514	1,216	1,661	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	11	15	14	11	15	78
ACCOUNTING	7	6	8	7	6	8	43
WORK COMP INS	22	19	27	23	19	26	135
SUPPLIES	11	9	13	12	9	13	66
TELEPHONE	52	45	64	57	45	62	325
EMPL BENEFITS	543	472	666	589	473	646	3,389
PAYROLL TAXES	235	204	288	255	205	280	1,468
TRAVEL	45	39	55	49	39	54	282
IN SERVICE	5	5	6	6	5	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	15	13	18	16	13	17	91
OWNERS COMP	210	182	257	228	183	250	1,309
INS-PROP,LIAB,WC	31	27	38	33	27	37	192
DEPRECIATION	112	98	138	122	98	134	702
RENT	279	242	342	302	243	332	1,739
MAINTENANCE	81	70	99	88	71	96	505
FEES & PUBLIC	13	11	16	14	11	16	82
ADVERTISING	6	6	8	7	6	8	40
	0	0	0	0	0	0	0
TOTAL	$5,604	$4,870	$6,871	$6,079	$4,884	$6,669	$34,977
FIXED ASSETS							
EQUIP - PRIOR	10,182	8,849	12,484	11,045	8,875	12,118	63,553
EQUIP - CURR	252	219	309	274	220	300	1,574
EQUIP - FULLY DEP	1,460	1,269	1,790	1,583	1,272	1,737	9,111
BLDG - PRIOR	1,077	936	1,321	1,169	939	1,282	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
SALARIES-ADMIN	$2,373	$2,364	$3,167	$2,721	$2,218	$2,944	$15,787
SALARIES-CLERIC	1,309	1,304	1,747	1,501	1,224	1,624	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	16	13	11	15	78
ACCOUNTING	6	6	9	7	6	8	43
WORK COMP INS	20	20	27	23	19	25	135
SUPPLIES	10	10	13	11	9	12	66
TELEPHONE	49	49	65	56	46	61	325
EMPL BENEFITS	510	508	680	584	476	632	3,389
PAYROLL TAXES	221	220	294	253	206	274	1,468
TRAVEL	42	42	56	49	40	53	282
IN SERVICE	5	5	6	6	5	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	18	16	13	17	91
OWNERS COMP	197	196	263	226	184	244	1,309
INS-PROP,LIAB,WC	29	29	39	33	27	36	192
DEPRECIATION	106	105	141	121	99	131	702
RENT	261	260	349	300	244	324	1,739
MAINTENANCE	76	76	101	87	71	94	505
FEES & PUBLIC	12	12	16	14	11	15	82
ADVERTISING	6	6	8	7	6	7	40
	0	0	0	0	0	0	0
TOTAL	$5,258	$5,238	$7,016	$6,029	$4,913	$6,523	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,555	9,517	12,748	10,954	8,928	11,851	63,553
EQUIP - CURR	237	236	316	271	221	294	1,574
EQUIP - FULLY DEP	1,370	1,364	1,828	1,570	1,280	1,699	9,111
BLDG - PRIOR	1,011	1,007	1,349	1,159	945	1,254	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
SALARIES-ADMIN	$2,373	$2,353	$3,329	$2,631	$2,024	$3,078	$15,787
SALARIES-CLERIC	1,309	1,298	1,837	1,451	1,117	1,698	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	16	13	10	15	78
ACCOUNTING	6	6	9	7	6	8	43
WORK COMP INS	20	20	29	23	17	26	135
SUPPLIES	10	10	14	11	9	13	66
TELEPHONE	49	48	69	54	42	63	325
EMPL BENEFITS	509	505	715	565	435	661	3,389
PAYROLL TAXES	221	219	309	245	188	286	1,468
TRAVEL	42	42	59	47	36	55	282
IN SERVICE	5	5	7	5	4	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	19	15	12	18	91
OWNERS COMP	197	195	276	218	168	255	1,309
INS-PROP,LIAB,WC	29	29	41	32	25	38	192
DEPRECIATION	106	105	148	117	90	137	702
RENT	261	259	367	290	223	339	1,739
MAINTENANCE	76	75	106	84	65	98	505
FEES & PUBLIC	12	12	17	14	10	16	82
ADVERTISING	6	6	8	7	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,257	$5,214	$7,375	$5,828	$4,484	$6,819	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,553	9,474	13,400	10,590	8,147	12,390	63,553
EQUIP - CURR	237	235	332	262	202	307	1,574
EQUIP - FULLY DEP	1,369	1,358	1,921	1,518	1,168	1,776	9,111
BLDG - PRIOR	1,011	1,002	1,418	1,121	862	1,311	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2001

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
SALARIES-ADMIN	$2,353	$2,350	$3,408	$2,576	$1,944	$3,157	$15,787
SALARIES-CLERIC	1,298	1,297	1,880	1,421	1,073	1,742	8,710
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	12	12	17	13	10	16	78
ACCOUNTING	6	6	9	7	5	9	43
WORK COMP INS	20	20	29	22	17	27	135
SUPPLIES	10	10	14	11	8	13	66
TELEPHONE	48	48	70	53	40	65	325
EMPL BENEFITS	505	505	732	553	417	678	3,389
PAYROLL TAXES	219	218	317	239	181	293	1,468
TRAVEL	42	42	61	46	35	56	282
IN SERVICE	5	5	7	5	4	6	32
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	14	14	20	15	11	18	91
OWNERS COMP	195	195	283	214	161	262	1,309
INS-PROP,LIAB,WC	29	29	42	31	24	38	192
DEPRECIATION	105	105	152	115	86	140	702
RENT	259	259	375	284	214	348	1,739
MAINTENANCE	75	75	109	82	62	101	505
FEES & PUBLIC	12	12	18	13	10	16	82
ADVERTISING	6	6	9	7	5	8	40
	0	0	0	0	0	0	0
TOTAL	$5,213	$5,207	$7,550	$5,706	$4,307	$6,994	$34,977
FIXED ASSETS							
EQUIP - PRIOR	9,472	9,461	13,718	10,368	7,827	12,707	63,553
EQUIP - CURR	235	234	340	257	194	315	1,574
EQUIP - FULLY DEP	1,358	1,356	1,967	1,486	1,122	1,822	9,111
BLDG - PRIOR	1,002	1,001	1,452	1,097	828	1,345	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES
USED ON MONTHLY ALLOCATIONS - PAGE 27

OCCUPIED DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2453	1828	2186	1874	663	1482	2008	12494
FEBRUAR	2205	1686	2168	1746	597	1442	1996	11840
MARCH	2383	1773	2434	1904	604	1569	2285	12952
APRIL	2273	1671	2387	1783	641	1496	2155	12406
MAY	2301	1691	2252	1910	600	1448	2073	12275
JUNE	2211	1730	2175	1793	603	1426	1906	11844
JULY	2317	1823	2396	1846	652	1459	1889	12382
AUGUST	2249	1817	2342	1861	673	1516	1966	12424
SEPTEM	2163	1790	2174	1709	665	1606	1899	12006
OCTOBER	2249	1815	2246	1709	627	1766	1986	12398
NOVEMBE	2288	1675	2189	1590	594	1689	2002	12027
DECEMBE	2294	1678	2228	1642	668	1664	2130	12304
TOTAL	27386	20977	27177	21367	7587	18563	24295	147352
								147352

OCCUPIED DAYS 2001	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,278	1,698	2,136	1,630	595	1,701	2,074	12,112
FEBRUAR	2,100	1,570	2,067	1,408	518	1,538	1,875	11,076
MARCH	2,277	1,656	2,349	1,605	558	1,660	2,366	12,471
APRIL	2,198	1,578	2,311	1,461	560	1,563	2,419	12,090
MAY	2,210	1,727	2,404	1,535	543	1,568	2,491	12,478
JUNE	2,141	1,615	2,368	1,691	304	1,673	2,417	12,209
JULY	2,114	1,602	2,434	2,119	0	1,702	2,441	12,412
AUGUST	1,947	1,692	2,387	2,112	0	1,697	2,317	12,152
SEPTEM	1,768	1,761	2,359	2,027	0	1,652	2,193	11,760
OCTOBER	1,815	1,800	2,546	2,012	0	1,548	2,354	12,075
NOVEMBE	1,733	1,731	2,510	1,897	0	1,432	2,325	11,628
DECEMBE	1,777	1,581	2,529	1,845	0	1,421	2,430	11,583
TOTAL	24,358	20,011	28,400	21,342	3,078	19,155	27,702	144,046
								144,046

ALLOCATION PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.196334	0.14631	0.174964	0.203057	0.118617	0.160717	1
FEBRUARY	0.186233	0.142399	0.183108	0.197889	0.121791	0.168581	1
MARCH	0.183987	0.13689	0.187925	0.193638	0.12114	0.176421	1
APRIL	0.183218	0.134693	0.192407	0.195389	0.120587	0.173706	1
MAY	0.187454	0.13776	0.183462	0.204481	0.117963	0.16888	1
JUNE	0.186677	0.146066	0.183637	0.202297	0.120399	0.160925	1
JULY	0.187126	0.14723	0.193507	0.201744	0.117832	0.15256	1
AUGUST	0.181021	0.146249	0.188506	0.20396	0.122022	0.158242	1
SEPTEMBER	0.18016	0.149092	0.181076	0.197734	0.133766	0.158171	1
OCTOBER	0.1814	0.146395	0.181158	0.188417	0.142442	0.160187	1
NOVEMBER	0.190239	0.13927	0.182007	0.181591	0.140434	0.166459	1
DECEMBER	0.186443	0.136378	0.181079	0.187744	0.135241	0.173114	1

ALLOCATION PERCENTAGE 2001	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	18.81%	14.02%	17.64%	18.37%	14.04%	17.12%	100.00%
FEBRUARY	18.96%	14.17%	18.66%	17.39%	13.89%	16.93%	100.00%
MARCH	18.26%	13.28%	18.84%	17.34%	13.31%	18.97%	100.00%
APRIL	18.18%	13.05%	19.11%	16.72%	12.93%	20.01%	100.00%
MAY	17.71%	13.84%	19.27%	16.65%	12.57%	19.96%	100.00%
JUNE	17.54%	13.23%	19.40%	16.34%	13.70%	19.80%	100.00%
JULY	17.03%	12.91%	19.61%	17.07%	13.71%	19.67%	100.00%
AUGUST	16.02%	13.92%	19.64%	17.38%	13.96%	19.07%	100.00%
SEPTEMBER	15.03%	14.97%	20.06%	17.24%	14.05%	18.65%	100.00%
OCTOBER	15.03%	14.91%	21.08%	16.66%	12.82%	19.49%	100.00%
NOVEMBER	14.90%	14.89%	21.59%	16.31%	12.32%	19.99%	100.00%
DECEMBER	15.34%	13.65%	21.83%	15.93%	12.27%	20.98%	100.00%